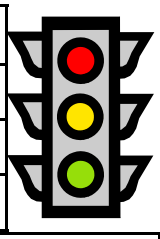
Virginia Asthma Action Plan

School Division: _____

Name	Date of Birth	Effective Dates / / to / /
Health Care Provider	Provider's Phone	
Parent/Guardian	Parent/Guardian Phone	Parent/Guardian Email:
Additional Emergency Contact	Contact Phone	Contact Email:



GREEN means Go!
Use CONTROL medicine daily
YELLOW means Caution!
Add RESCUE medicine
RED means DANGER!
Get help from a doctor now!

Asthma Severity

☐ **Intermittent** ***or***

Persistent: ☐ Mild ☐ Moderate ☐ Severe

Asthma Triggers (Things that make your asthma worse)

☐ Colds ☐ Smoke (tobacco, incense) ☐ Pollen ☐ Dust
☐ Animals:_____ ☐ Strong odors ☐ Mold/moisture
☐ Pests (rodents, cockroaches) ☐ Stress/Emotions ☐Exercise
☐Gastroesophageal reflux ☐ Season (circle):Fall, Winter, Spring, Summer
☐ Other:_____

Last Flu Shot: / /

Pneumonia Shot: / /

Green Zone: Go! — Take these CONTROL (PREVENTION) Medicines EVERY Day

You have **ALL** of these:

- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night

Peak flow in this area:
_____ to _____
(More than 80% of Personal Best)
Personal best peak flow:_____

☐ No control medicines required. **Always rinse mouth after using your daily inhaled medicine.**

☐ _____, _____ puff (s) **MDI with Spacer** __ times a day
Inhaled Corticosteroid or Inhaled corticosteroid/long-acting β-agonist

☐ _____, _____ nebulizer treatment (s) __ times a day
Inhaled Corticosteroid

☐ _____, take _____ by mouth once daily at bedtime
Leukotriene antagonist

For asthma with exercise, ADD:
☐ _____, _____ puffs with spacer 15 minutes before exercise
Fast acting Inhaled β-agonist

For nasal/environmental allergy, ADD:
☐ _____, use _____ spray (s) per nostril _____ times a day
Nasal corticosteroid

Yellow Zone: Caution! — Continue CONTROL Medicines and ADD RESCUE Medicines

You have **ANY** of these:

- First sign of a cold
- Cough or mild wheeze
- Tight chest
- Problems sleeping, working, or playing

Peak flow in this area:
_____ to _____
(60%-80% of Personal Best)

☐ _____, _____ puffs with spacer every _____ hours as needed
Inhaled b-agonist

☐ _____, _____ nebulizer treatment (s) every _____ hours as needed
Inhaled b-agonist

☐ Other _____

Call your Healthcare Provider if you need rescue medicine for more than 24 hours or two times a week, or if your rescue medicine doesn't work

Red Zone: DANGER! — Continue CONTROL & RESCUE Medicines and GET HELP!

You have **ANY** of these:

- Can't talk, eat, or walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Ribs show

Peak flow in this area:
_____ to _____
(Less than 60% of Personal Best)

☐ _____, __ puffs with spacer **every 15 minutes**, for **THREE** treatments
Inhaled β-agonist

☐ _____, __ nebulizer treatment **every 15 minutes**, for **THREE** treatments
Inhaled β-agonist

Call your doctor while administering the treatments.

☐ Other_____

IF YOU CANNOT CONTACT YOUR DOCTOR:
Call 911 for an ambulance,
or go directly to the Emergency Department!

SCHOOL MEDICATION CONSENT AND HEALTH CARE PROVIDER ORDER FOR CHILDREN/YOUTH

CHECK ALL THAT APPLY:

____ **Student has been instructed in the proper use of all of his/her asthma medications, and in my opinion, CAN CARRY AND SELF-ADMINISTER HIS or HER INHALER AT SCHOOL.**

____ **Student is to notify his/her designated school health officials after using inhaler at school.**

____ **Student needs supervision or assistance to use his/her inhaler.**

____ **Student should NOT carry his/her inhaler while at school.**

MD/NP/PA SIGNATURE: _____ **DATE**_____

REQUIRED SIGNATURES:

I give permission for school personnel to follow this plan, administer medication and care for my child and contact my provider if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/ monitoring devices. I approve this Asthma Management Plan for my child.

PARENT/GUARDIAN _____ **Date** _____

SCHOOL NURSE/DESIGNEE _____ **Date** _____

OTHER _____ **Date** _____

Virginia Asthma Action Plan approved by the Virginia Asthma Coalition (VAC) 4/11
Based on NAEPP Guidelines and modified with permission from the D.C. Asthma Action Plan via District of Columbia Department of Health, DC Control Asthma Now, and District of Columbia Asthma Partnership